FOR BHF USE

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IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

I. IDPH Facility ID Number: 0047555

Facility Name: Sandwich Rehabilitation & Health Care Center

Address: 902 East Arnold Street (Number) Sandwich (City) 60548 (Zip Code)

County: Dekalb

Telephone Number: 815-786-8409 **Fax #** 815-786-3830

HFS ID Number: 203224201001

Date of Initial License for Current Owners: 10/01/05

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** 312-634-4581
Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) McGladrey & Pullen, LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	8,522	4,480		13,002	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,522	4,480		13,002	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.54%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Independent Living

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Cent # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	113,732	5,407	3,188	122,327		122,327	(34,307)	88,020			1
2	Food Purchase		69,552		69,552		69,552	(25,780)	43,772			2
3	Housekeeping	78,221	8,961		87,182		87,182	(25,330)	61,852			3
4	Laundry	22,676	5,405		28,081		28,081	(8,172)	19,909			4
5	Heat and Other Utilities			66,812	66,812		66,812	(19,272)	47,540			5
6	Maintenance	13,772	24,407	10,245	48,424		48,424	(10,888)	37,536			6
7	Other (specify):* Mgmt. Alloc of Bene							805	805			7
8	TOTAL General Services	228,401	113,732	80,245	422,378		422,378	(122,944)	299,434			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	562,579	26,756	737	590,072		590,072	3,989	594,061			10
10a	Therapy			5,143	5,143		5,143	307	5,450			10a
11	Activities	26,853	629	4,713	32,195		32,195		32,195			11
12	Social Services	28,984			28,984		28,984		28,984			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt. Alloc of Bene							1,256	1,256			15
16	TOTAL Health Care and Programs	618,416	27,385	23,793	669,594		669,594	5,552	675,146			16
	C. General Administration											
17	Administrative	52,500		30,000	82,500		82,500	(20,115)	62,385			17
18	Directors Fees											18
19	Professional Services			2,532	2,532		2,532	5,661	8,193			19
20	Dues, Fees, Subscriptions & Promotions			4,826	4,826		4,826	637	5,463			20
21	Clerical & General Office Expenses	26,615	3,377	11,711	41,703		41,703	18,426	60,129			21
22	Employee Benefits & Payroll Taxes			145,008	145,008		145,008	4,555	149,563			22
23	Inservice Training & Education			159	159		159	119	278			23
24	Travel and Seminar							477	477			24
25	Other Admin. Staff Transportation			4,008	4,008		4,008	1,402	5,410			25
26	Insurance-Prop.Liab.Malpractice			19,526	19,526		19,526	733	20,259			26
27	Other (specify):* Mgmt. Alloc of Bene							3,577	3,577			27
28	TOTAL General Administration	79,115	3,377	217,770	300,262		300,262	15,472	315,734			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	925,932	144,494	321,808	1,392,234		1,392,234	(101,920)	1,290,314			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center #0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			18,137	18,137		18,137	2,334	20,471			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,865	25,865		25,865	11,551	37,416			32
33	Real Estate Taxes			60,000	60,000		60,000	1,285	61,285			33
34	Rent-Facility & Grounds							585	585			34
35	Rent-Equipment & Vehicles			4,386	4,386		4,386	383	4,769			35
36	Other (specify):*											36
37	TOTAL Ownership			108,388	108,388		108,388	16,138	124,526			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		338		338		338		338			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,492	34,492		34,492		34,492			42
43	Other (specify):* Nonallowable Cost	23,298		18,617	41,915		41,915	(41,915)				43
44	TOTAL Special Cost Centers	23,298	338	53,109	76,745		76,745	(41,915)	34,830			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	949,230	144,832	483,305	1,577,367		1,577,367	(127,697)	1,449,670			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,032)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,506)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10	30		9
10	Interest and Other Investment Income	(1,802)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(237)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(702)	43		24
25	Fund Raising, Advertising and Promotional	(6,257)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(157,561)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (173,087)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	45,390		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 45,390		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (127,697)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Sandwich Rehabilitation & Health Care Center

ID# 0047555

Report Period Beginning: 01/01/06

Ending: 12/31/06

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (4,257)	43	1
2	Labs-Part A	(528)	43	2
3	X-Rays-Part A	(218)	43	3
4	Offset Vending Machine revenue	(912)	43	4
5	Salaries-Marketing/Other	(23,298)	43	5
6	Disallow non-allowable travel expense	(3,422)	24	6
7	Independent Living depreciation offset	(2,006)	30	7
8	Independent Living - Dietary	(35,599)	1	8
9	Independent Living - Food	(20,241)	2	9
10	Independent Living - Housekeeping	(25,372)	3	10
11	Independent Living - Laundry	(8,172)	4	11
12	Independent Living - Utilities	(19,444)	5	12
13	Independent Living - Maintenance	(14,092)	6	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(157,561)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(35,599)	924	0	368	0	0	0	0	0	0	0	(34,307)	1
2	Food Purchase	(21,273)	45	0	3	0	0	0	0	0	0	0	(21,225)	2
3	Housekeeping	(25,372)	41	0	1	0	0	0	0	0	0	0	(25,330)	3
4	Laundry	(8,172)	0	0	0	0	0	0	0	0	0	0	(8,172)	4
5	Heat and Other Utilities	(19,444)	172	0	0	0	0	0	0	0	0	0	(19,272)	5
6	Maintenance	(14,092)	2,352	0	852	0	0	0	0	0	0	0	(10,888)	6
7	Other (specify):*	0	371	0	434	0	0	0	0	0	0	0	805	7
8	TOTAL General Services	(123,952)	3,905	0	1,658	0	0	0	0	0	0	0	(118,389)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3,342	0	647	0	0	0	0	0	0	0	3,989	10
10a	Therapy	0	307	0	0	0	0	0	0	0	0	0	307	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,034	0	222	0	0	0	0	0	0	0	1,256	15
16	TOTAL Health Care and Programs	0	4,683	0	869	0	0	0	0	0	0	0	5,552	16
	C. General Administration													
17	Administrative	0	(20,887)	0	772	0	0	0	0	0	0	0	(20,115)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,990	0	1,671	0	0	0	0	0	0	0	5,661	19
20	Fees, Subscriptions & Promotions	0	391	0	246	0	0	0	0	0	0	0	637	20
21	Clerical & General Office Expenses	0	0	14,690	3,736	0	0	0	0	0	0	0	18,426	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	119	0	0	0	0	0	0	0	0	119	23
24	Travel and Seminar	(3,422)	0	3,556	343	0	0	0	0	0	0	0	477	24
25	Other Admin. Staff Transportation	0	0	946	456	0	0	0	0	0	0	0	1,402	25
26	Insurance-Prop.Liab.Malpractice	0	0	700	33	0	0	0	0	0	0	0	733	26
27	Other (specify):*	0	0	2,596	981	0	0	0	0	0	0	0	3,577	27
28	TOTAL General Administration	(3,422)	(16,506)	22,607	8,238	0	0	0	0	0	0	0	10,917	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(127,374)	(7,918)	22,607	10,765	0	0	0	0	0	0	0	(101,920)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 **Report Period Beginning:** 01/01/06 **Ending:** 12/31/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,996)	0	3,622	708	0	0	0	0	0	0	0	2,334	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,802)	0	2,012	11,341	0	0	0	0	0	0	0	11,551	32
33	Real Estate Taxes	0	0	425	860	0	0	0	0	0	0	0	1,285	33
34	Rent-Facility & Grounds	0	0	412	173	0	0	0	0	0	0	0	585	34
35	Rent-Equipment & Vehicles	0	0	216	167	0	0	0	0	0	0	0	383	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,798)	0	6,687	13,249	0	0	0	0	0	0	0	16,138	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(41,915)	0	0	0	0	0	0	0	0	0	0	(41,915)	43
44	**TOTAL Special Cost Centers**	(41,915)	0	0	0	0	0	0	0	0	0	0	(41,915)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(173,087)	(7,918)	29,294	24,014	0	0	0	0	0	0	0	(127,697)	45

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 924	$ 924	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	45	45	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	41	41	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	172	172	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,352	2,352	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	371	371	6
7	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,342	3,342	7
8	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	307	307	8
9	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,034	1,034	9
10	V	17	Administrative	30,000	Petersen Health Care, Inc.	100.00%	9,113	(20,887)	10
11	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,990	3,990	11
12	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	391	391	12
13	V								13
14	Total			$ 30,000			$ 22,082	$ * (7,918)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 14,690	$ 14,690	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	119	119	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	3,556	3,556	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	946	946	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	700	700	19
20	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,596	2,596	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,622	3,622	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,012	2,012	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	425	425	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	412	412	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	216	216	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 29,294	$ * 29,294	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 368	$ 368	15
16	V	2	Food		Petersen Health Care, Inc.	100.00%	3	3	16
17	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	1	1	17
18	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	852	852	18
19	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	434	434	19
20	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	647	647	20
21	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	222	222	21
22	V	17	Administrative		Petersen Health Care, Inc.	100.00%	772	772	22
23	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	1,671	1,671	23
24	V	20	Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	246	246	24
25	V	21	Clerical & General Office		Petersen Health Care, Inc.	100.00%	3,736	3,736	25
26	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	343	343	26
27	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	456	456	27
28	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	33	33	28
29	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	981	981	29
30	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	708	708	30
31	V	32	Interest		Petersen Health Care, Inc.	100.00%	11,341	11,341	31
32	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	860	860	32
33	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	173	173	33
34	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	167	167	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 24,014	$ * 24,014	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Cen # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.57	1.14	Salary	$ 9,112	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,112		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,141,463	56	$ 81,179	$ 80,967	13,002	$ 924	1
2	2	Food	Patient Days	1,141,463	56	3,989		13,002	45	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		13,002	41	3
4	5	Utilities	Patient Days	1,141,463	56	15,054		13,002	172	4
5	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	13,002	2,352	5
6	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526		13,002	371	6
7	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	13,002	3,342	7
8	10A	Therapy	Patient Days	1,141,463	56	26,945		13,002	307	8
9	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724		13,002	1,034	9
10	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	13,002	9,113	10
11	19	Professional Services	Patient Days	1,141,463	56	350,361	4,303	13,002	3,990	11
12	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325		13,002	391	12
13	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	13,002	14,690	13
14	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		13,002	119	14
15	24	Travel and Seminar	Patient Days	1,141,463	56	312,259		13,002	3,556	15
16	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062		13,002	946	16
17	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457		13,002	700	17
18	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912		13,002	2,596	18
19	30	Depreciation	Patient Days	1,141,463	56	317,964		13,002	3,622	19
20	32	Interest	Patient Days	1,141,463	56	176,614		13,002	2,012	20
21	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282		13,002	425	21
22	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		13,002	412	22
23	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		13,002	216	23
24										24
25	TOTALS					$ 4,510,235	$ 2,239,302		$ 51,376	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 West Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	427,669	46	$ 12,081	$ 11,958	13,002	$ 368	1
2	2	Food	Patient Days	427,669	46	93	0	13,002	3	2
3	3	Housekeeping	Patient Days	427,669	46	28	0	13,002	1	3
4	6	Maintenance	Patient Days	427,669	46	28,012	28,012	13,002	852	4
5	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282	0	13,002	434	5
6	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	13,002	647	6
7	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301	0	13,002	222	7
8	17	Administrative	Patient Days	427,669	46	25,391	25,391	13,002	772	8
9	19	Professional Services	Patient Days	427,669	46	54,971	0	13,002	1,671	9
10	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088	0	13,002	246	10
11	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	13,002	3,736	11
12	24	Travel and Seminar	Patient Days	427,669	46	11,280	0	13,002	343	12
13	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003	0	13,002	456	13
14	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087	0	13,002	33	14
15	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265	0	13,002	981	15
16	30	Depreciation	Patient Days	427,669	46	23,301	0	13,002	708	16
17	32	Interest	Patient Days	427,669	46	373,049	0	13,002	11,341	17
18	33	Real Estate Taxes	Patient Days	427,669	46	28,282	0	13,002	860	18
19	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700	0	13,002	173	19
20	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479	0	13,002	167	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 789,885	$ 150,702		$ 24,014	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Cent # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	$ 230,000	$ 226,643	09/20/2010	Varies	$ 1,692	1
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	40,000	39,927	09/20/2010	0.1000	24,172	2
3												3
4							Allocated from Home Office				13,353	4
5							Offset Interest Income				(1,802)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 270,000	$ 266,570			$ 37,416	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 270,000	$ 266,570			$ 37,416	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center **#** 0047555 **Report Period Beginning:** 01/01/06 **Ending:** 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 59,308	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2005**	$ 59,308	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 60,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	**Allocated from Home Office**	1,285	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 61,285	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2001		8
	2002		9
	2003		10
	2004		11
	2005	59,308	12

Tax accrual calculated based on prior year tax bills.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sandwich Rehabilitation & Health Care Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0047555

CONTACT PERSON REGARDING THIS REPORT Mark Peterson

TELEPHONE 618-283-4262 FAX #: 618-283-4313

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-25-252-015	Nursing Home	$ 32,175.78	$ 32,175.78
2.	19-25-252-016	Nursing Home	$ 27,131.86	$ 27,131.86
3.			$	$
4.		Home Office Building	$	$ 1,285.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 59,307.64	$ 60,592.64

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not comsidered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,626 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	94,961	2005	$ 12,150	1
2					2
3	TOTALS	94,961		$ 12,150	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	63		2005	1973	$ 157,386	$ 6,320	25	$ 6,295	$ (25)	$ 9,443	4
5											5
6	Home										6
7	Office										7
8	Allocation			2006	7,754			339	339	339	8
	Improvement Type**										
9	Original Land Improvements			2005	10,000	667	15	667		1,000	9
10	Sidewalks			2006	8,685	145	15	193	48	193	10
11											11
12											12
13	Home Office Allocation			2006	461			43	43	43	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 184,286	$ 7,132		$ 7,537	$ 405	$ 11,018	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 48,410	$ 8,246	$ 8,205	$ (41)	3-7	$ 12,308	71
72	Current Year Purchases	8,051	753	781	28	7	781	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,948	3,948			74
75	TOTALS	$ 56,461	$ 8,999	$ 12,934	$ 3,935		$ 13,089	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 252,897	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,131	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,471	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,340	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 24,107	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Independent Living (2005)	$ 49,964	$ 2,006	$ 3,009	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 49,964	$ 2,006	$ 3,009	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				585			6
7	TOTAL				$ 585 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2007	$
13.	/2008	$
14.	/2009	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 4,769 Description: Copier - 2,880; Dishwasher - 767; Nursing Eqpt. - 1,122
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	71	$ 3,546	$	71	$ 3,546	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		32	1,597		32	1,597	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				322		322	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39(2)					16		16	13
14	TOTAL			$	103	$ 5,143	$ 338	103	$ 5,481	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 **Report Period Beginning:** 01/01/06 **Ending:** 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/06 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 19,331	$ 19,331	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	164,747	164,747	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,469	7,469	7
8	Accounts Receivable (owners or related parties)	4,561	4,561	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 196,108	$ 196,108	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	30,835	12,150	13
14	Buildings, at Historical Cost	207,350	165,140	14
15	Leasehold Improvements, at Historical Cost		19,146	15
16	Equipment, at Historical Cost	56,461	56,461	16
17	Accumulated Depreciation (book methods)	(21,269)	(24,107)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 273,377	$ 228,790	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 469,485	$ 424,898	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,311	$ 106,311	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,183	18,183	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,487	5,487	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,000	60,000	32
33	Accrued Interest Payable	2,756	2,756	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholding Liabilities	8,767	8,767	36
37	Security Deposits	17,903	17,903	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 219,407	$ 219,407	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	39,927	39,927	40
41	Bonds Payable	226,643	226,643	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 266,570	$ 266,570	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 485,977	$ 485,977	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (16,492)	$ (61,079)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 469,485	$ 424,898	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 23,215	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 23,215	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(39,708)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (39,707)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (16,492)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,534,638	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,534,638	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,032	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,032	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,802	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,802	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	107	28
28a	Misc Income - Laundry	80	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 187	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,537,659	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	422,378	31
32	Health Care	669,594	32
33	General Administration	300,262	33
	B. Capital Expense		
34	Ownership	108,388	34
	C. Ancillary Expense		
35	Special Cost Centers	42,253	35
36	Provider Participation Fee	34,492	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,577,367	40
41	**Income before Income Taxes (line 30 minus line 40)****	(39,708)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (39,708)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This facility is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,223	2,223	$ 29,463	$ 13.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,152	3,645	122,323	33.56	3
4	Licensed Practical Nurses	4,790	4,960	113,968	22.98	4
5	CNAs & Orderlies	20,650	21,289	250,054	11.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,008	2,016	24,901	12.35	9
10	Activity Assistants	231	252	1,952	7.75	10
11	Social Service Workers	1,423	1,423	28,984	20.37	11
12	Dietician					12
13	Food Service Supervisor	2,075	2,075	33,419	16.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,030	9,138	80,313	8.79	15
16	Dishwashers					16
17	Maintenance Workers	1,241	1,241	13,772	11.10	17
18	Housekeepers	7,639	7,672	78,221	10.20	18
19	Laundry	3,298	3,298	22,676	6.88	19
20	Administrator	1,954	1,954	52,500	26.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,040	2,072	26,615	12.85	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coordin	2,056	2,056	46,771	22.75	32
33	Other(specify) Marketing	2,006	2,006	23,298	11.61	33
34	TOTAL (lines 1 - 33)	65,816	67,320	$ 949,230 *	$ 14.10	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	72	$ 3,188	1(3)	35
36	Medical Director	Monthly	13,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	737	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	72	$ 17,125		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judith Wright	Administrator	0	$ 52,500
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 52,500

B. Administrative - Other

Description	Amount
Management Fee Expense (Eliminated on Sch V, Col 7)	$ 30,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 30,000

C. Professional Services

Vendor/Payee	Type	Amount
LTC Solutions	Computer Services	$ 1,850
Comcast	Computer Services	682
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 2,532

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,914
Unemployment Compensation Insurance	46,542
FICA Taxes	70,532
Employee Health Insurance	328
Employee Meals	4,555
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	35
Employee Relations	3,657
TOTAL (agree to Schedule V, line 22, col.8)	$ 149,563

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,375
Advertising: Employee Recruitment	1,358
Health Care Worker Background Check	
(Indicate # of checks performed 138)	1,660
Patient Background Checks	0
Miscellaneous Dues & Subscriptions	433
Allocated from Home Office	637
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,463

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Allocated from Home Office	3,899
Less: Disallowed travel expense	(3,422)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 477

* Attach copy of IMRF notifications

**See instructions.

Petersen Health Care, Inc. (Sandwich)
Provider Number - 0047555
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	2,532
Allocated from Home Office	
Other Professional Fees	3,937
Legal	53
Other Professional Fees - PHO	1,621
Legal - PHO	50
Total (agree to Schedule V, line 19, column 8)	8,193

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			$		$	$	$	$	$	$	$	$	$
2								N/A					
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/06 Ending: 12/31/06

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,261** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **34,492**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes, See attached** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,555** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,032**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees